STATE OF CONNECTICUT-
DEPARTMENT OF PUBLIC HEALTH

OPTOMETRY LICENSURE
Verification of Licensure/Certification/Registration

Applicant- Complete the top portion of this form and forward it to each state where you have been licensed, certified or registered as an optometrist (make copies as necessary).

Name: _____
Last First Middle Maiden

Address:_____
No. & Street City State Zip Code

Original License, Certification or Registration number_____Date Issued_____
(in the state to which the form is being forwarded)

I hereby authorize the _____ to furnish the Connecticut Department of Public Health the information requested below.

Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE – FOR LICENSING AGENCY USE ONLY

This is to certify that the above named individual was issued license, certification or registration number _____to practice as an optometrist effective _____.

Current Status: Active _____
Inactive _____
Lapsed _____

Date license, certification or registration expires: _____

Has this individual ever been subjected to disciplinary action of any type or is this individual currently the subject of a pending disciplinary action or unresolved complaint? **Yes** ☐ **No** ☐ If yes, please forward all publicly disclosable information regarding the individual's status and the basis for same. Please advise this office if you require a consent for release of this information from the applicant.

Signed: _____ Title _____

State: _____ Date_____

Telephone Number: _____

Email: _____

PLEASE COMPLETE AND RETURN DIRECTLY TO:

DEPARTMENT OF PUBLIC HEALTH
OPTOMETRY LICENSURE
410 CAPITOL AVE., MS# 12APP
P.O. BOX 340308
HARTFORD, CT 06134-0308
Fax: (860) 707-1931